Washington State Department of Health
Board of Pharmacy
PO Box 1099
Olympia WA 98507-1099
(360) 236-4843

BOARD USE ONLY	
☐ Pharmacy Location	$365.00
☐ CSA	80.00
☐ Pharmacy Ancillary Util.	65.00
☐ Differential Hours	35.00
TOTAL	$ _____

(Licensing Cycle June 1–May 31)
All application fees are nonrefundable

Pharmacy License Application

All blanks must be complete: If not applicable, enter N/A

This is for: ☐ New Location ☐ Change of Location ☐ Change of Ownership
☐ ***Name Change Only ($15.00 duplicate fee.)***

Check all that apply

Type of Pharmacy: ☐ **Community/Retail** ☐ **Hospital** ☐ **Long-term Care (LTC)** ☐ **Parenteral**
☐ **Mail-Order** ☐ **Non-profit** ☐ **For Profit**
☐ **Internet (web address)** _____
☐ **Other (explain)** _____

Demographic Information

PHARMACY NAME		DATE PHARMACY WILL BE READY FOR INSPECTION	
PHARMACY LOCATION ADDRESS	CITY	STATE	ZIP CODE
PHARMACY MAILING ADDRESS (IF DIFFERENT)	CITY	STATE	ZIP CODE
NAME AND ADDRESS OF CORPORATION/PARENT COMPANY, PARTNERSHIP OR PROPRIETOR			
STATE OF INCORPORATION	CORPORATE NUMBER	DATE OF CORPORATION	OTHER STATES OF LICENSURE
OWNER'S TELEPHONE ( )	PHARMACY'S TELEPHONE ( )	FAX NUMBER ( )	
CONTACT PERSON	TELEPHONE NUMBER	EMAIL ADDRESS	
PHARMACIST IN CHARGE	LICENSE NUMBER	DATE OF APPOINTMENT	

Ownership Information–attach additional sheets as needed

Type of Ownership: ☐ **Sole Proprietor** ☐ **Partnership** ☐ **Corporation** ☐ **Government Owned**
☐ **Limited Liability Company**

List names, addresses & titles of corporate officers, partners or owners

NAME	ADDRESS	TITLE

Continued on Reverse

Ownership Information–attach additional sheets as needed

NAME AND ADDRESS OF CORPORATION/PARENT COMPANY, PARTNERSHIP OR PROPRIETOR		
PREVIOUS NAME OF PHARMACY	PREVIOUS/CURRENT WASHINGTON LICENSE#	EFFECTIVE DATE OF OWNERSHIP CHANGE
PREVIOUS LOCATION	DATE OF LAST STATE INSPECTION	

Indicate the hours the Pharmacy will be open

Monday—Friday	Saturday	Sunday	Holidays

List all Pharmacist–attach additional sheets if needed

Certification

I, _____ , being first duly sworn upon oath, depose and say that the answers to the foregoing questions and statements made in the above application are true and correct.

_____ _____

Signature of Applicant Date

Subscribed and sworn to before me this _____ day of _____ , 20 _____ .

Notary Signature _____

For the State of _____

SEAL

Residing at _____

My Commission Expires _____

Official Use Only

Washington State Records Center